

Getting Started with 2010 PQRI Reporting of Measures Groups

Introduction:

This document contains general implementation guidance for reporting 2010 Physician Quality Reporting Initiative (PQRI) Measures Groups. Measures groups include reporting on a group of clinically-related measures identified by CMS for use in PQRI, either through claims-based and/or registry-based submission. Thirteen measures groups have been established for 2010 PQRI: Diabetes Mellitus, Chronic Kidney Disease (CKD), Preventive Care, Coronary Artery Bypass Graft (CABG), Rheumatoid Arthritis, Perioperative Care, Back Pain, Hepatitis C, Heart Failure, Coronary Artery Disease (CAD), Ischemic Vascular Disease (IVD), HIV/AIDS, and Community-Acquired Pneumonia (CAP).

An eligible professional (EP) may choose to pursue more than one 2010 PQRI reporting option. However, an EP who satisfactorily reports under more than one reporting option will earn a maximum of one incentive payment equal to 2.0% of their total estimated allowed charges for Medicare Part B Physician Fee Schedule (PFS) covered professional services furnished during the longest reporting period for which he or she satisfied reporting criteria.

There are two reporting periods available to EPs to report 2010 PQRI measures groups: a) 12-month reporting period from January 1 through December 31, 2010 **OR** b) a six-month reporting period from July 1 through December 31, 2010. The six month reporting period allows those EPs who may have decided to participate later in the year to begin reporting. Those EPs who satisfactorily report quality data under the measures groups reporting option may earn an incentive payment equal to 2.0% of their total estimated allowed charges for Medicare Part B PFS covered professional services furnished during the reporting period. This document provides strategies and information to facilitate satisfactory reporting by each EP who wishes to pursue this alternative.

The *2010 PQRI Measures Groups Specifications Manual*, which can be found at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage, contains detailed descriptions for each quality measure within each measures group. Denominator coding has been modified from the original individual measure as specified by the measure developer to allow for implementation as a measures group. To get started, review the *2010 PQRI Measures Groups Specifications Manual* to determine if a particular measures group is applicable to Medicare services the practice provides.

Measures Groups Participation Strategy:

1. Plan and implement processes within the practice to ensure satisfactory reporting of measures groups.
2. Become familiar with the following two methods for satisfactory reporting of measures groups. The two methods for measures groups are:

30 Patient Sample Method:

- For claims-based submissions, 30 unique Medicare Part B PFS patients who meet patient sample criteria (see Patient Sample Criteria Table below) for the measures group. For claims-based submissions, PQRI analysis will be initiated when the measures group-specific intent G-code is submitted on a claim. However all claims meeting patient sample criteria in the selected reporting period will be considered in the analysis regardless of the date of service the measures group-specific intent G-code is submitted. If the EP does not have a minimum of 30 unique patients who meet patient sample criteria for the measures

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group, the EP is not incentive eligible and should either choose another measures group or choose another reporting option. Please refer to Appendix A: 2010 PQRI Participation Decision Tree.

- For registry-based submissions, EPs must report on all applicable measures within the selected measures group for a minimum sample of 30 unique patients (which may include non-Medicare Part B PFS patients) who meet patient sample criteria for the measures group.
- For both claims-based and registry-based submissions, all applicable measures within the group must be reported at least once for each patient within the sample population seen by the EP during the reporting period (January 1 through December 31, 2010) for each of the 30 unique patients.

OR

80% Patient Sample Method:

- All Medicare Part B PFS patients seen during the reporting period (either January 1 through December 31, 2010 **OR** July 1 through December 31, 2010) who meet patient sample criteria (see Patient Sample Criteria Table below) for the measures group. For claims-based submissions, PQRI analysis will be initiated when the measures group-specific intent G-code is submitted on a claim. However all claims meeting patient sample criteria in the selected reporting period will be considered in the analysis regardless of the date of service the measures group-specific intent G-code is submitted. A minimum of 80% of this patient sample must be reported for all applicable measures within the measures group according to each measures group's reporting instructions contained within each group's overview section.
 - For the 12-month reporting period, a minimum of 15 patients must meet the measures group patient sample criteria to report satisfactorily. For the six-month reporting period, a minimum of 8 patients must meet the measures group patient sample criteria to report satisfactorily. If the minimum number of patients does not meet the measures group patient sample criteria, the EP is not incentive eligible.
3. Determine the patient sample based on the patient sample criteria, which is used for both the 30 Patient Sample Method and the 80% Patient Sample Method. The following table contains patient sample criteria (common codes) that will qualify an EP's patient for inclusion in the measures group analysis. For claims-based submissions, claims must contain a line-item ICD-9-CM diagnosis code (where applicable) accompanied by a specific CPT patient encounter code. All diagnoses included on the base claim are considered in PQRI analysis.

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Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Diabetes Mellitus 18–75 years	97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Chronic Kidney Disease (CKD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215,,	585.4, 585.5
Preventive Care 50 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	
Coronary Artery Bypass Graft (CABG) 18 years and older	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536	
Rheumatoid Arthritis 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	714.0, 714.1, 714.2, 714.81

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Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Perioperative Care 18 years and older	19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 22558, 22600, 22612, 22630, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 39545, 39561, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 44005, 44010, 44020, 44021, 44050, 44055, 44120, 44125, 44126, 44127, 44130, 47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49215, 50320, 50340, 50360, 50365, 50370, 50380, 60521, 60522, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276	

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Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Back Pain 18-79 years	<p>Diagnosis codes with CPT codes: 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215,</p> <p style="text-align: center;">OR</p> <p>22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200</p>	<p>Diagnosis codes for CPT 9XXXX codes: 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2</p>
Hepatitis C 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215,	070.54
Heart Failure (HF) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350	389.91, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 425.0, 425.1, 425.2, 425.3, 425.4, 425.5, 425.7, 425.8, 425.9, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Coronary Artery Disease (CAD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82

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Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Ischemic Vascular Disease (IVD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99211, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456 92980, 92982, 92995, 99217, 99218, 99219, 99220, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 33140	410.11 , 410.21 , 410.31, 410.41, 410.51, 410.61, 410.71 , 410.81 , 410.91 , 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9,, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91,, 440.1, 440.2, 440.4, 444.0, 444.1, 444.21, 444.22, 444.8, 444.9, 445.0, 445.8
HIV/AIDS 13 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215,	042, V08, 079.53
Community-Acquired Pneumonia (CAP) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99291, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0

4. For claims-based submissions, to initiate reporting of measures groups submit by using the measures group-specific intent G-codes which will indicate your intention to begin reporting on a measures group. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-codes have been included for registry only measures groups for use by registries that utilize claims data.

Claims and Registry G-codes

G8485: I intend to report the Diabetes Mellitus Measures Group

G8487: I intend to report the Chronic Kidney Disease (CKD) Measures Group

G8486: I intend to report the Preventive Care Measures Group

G8490: I intend to report the Rheumatoid Arthritis Measures Group

G8492: I intend to report the Perioperative Care Measures Group

G8493: I intend to report the Back Pain Measures Group

G8545: I intend to report the Hepatitis C Measures Group

G8547: I intend to report the Ischemic Vascular Disease (IVD) Measures Group

G8546: I intend to report the Community-Acquired Pneumonia (CAP) Measures Group

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Registry only G-codes

G8544: I intend to report the Coronary Artery Bypass Graft (CABG) Measures Group

G8548: I intend to report the Heart Failure (HF) Measures Group

G8489: I intend to report the Coronary Artery Disease (CAD) Measures Group

G8491: I intend to report the HIV/AIDS Measures Group

5. Report all applicable measures for the measure group on each denominator-eligible patient included in the patient sample for each individual EP. Report QDCs as instructed in the *2010 PQRI Measures Groups Specifications Manual* on all applicable measures within the measures group for each patient included in the sample population for each individual EP. For claims-based submissions, EPs may choose to submit QDCs either on a current claim or on a claim representing a subsequent visit, particularly if the quality action has changed. For example, a new laboratory value may be available at a subsequent visit. Only one instance of reporting for each patient included in the sample population will be used in PQRI analysis to calculate reporting and performance rates for each measure within a group.

For claims-based submissions, if all quality actions for the applicable measures in the measures group have been performed for the patient, one composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. This composite G-code has also been created for registry only measures groups for use by registries that utilize claims data. However, it is not necessary to submit this composite G-code for registry-based submissions. Refer to the *2010 PQRI Measures Groups Specifications Manual* for detailed instructions about how to report quality-data codes for each of the measures group at

http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage.

An EP is only required to report QDCs on those individual measures in the measures group that meet the criteria (e.g. age or gender) according to the *2010 PQRI Measures Groups Specifications Manual*. For example, if an EP is reporting the Preventive Care Measures Group for a 52-year old female patient, only seven measures out of ten apply. See the Preventive Measures Group Demographic Criteria table on the next page.

Preventive Measures Group Demographic Criteria		
Age	Measures for Male Patients	Measures for Female Patients
<50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis
50-64 years	110, 113, 114, 115, 128, 173	110, 112, 113, 114, 115, 128, 173
65-69 years	110, 111, 113, 114, 115, 128, 173	39, 48, 110, 111, 112, 113, 114, 115, 128, 173
70-75 years	110, 111, 113, 114, 115, 128, 173	39, 48, 110, 111, 113, 114, 115, 128, 173
≥76 years	110, 111, 114, 115, 128, 173	39, 48, 110, 111, 114, 115, 128, 173

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Claims-Based Reporting Principles

The following principles apply to the reporting of QDCs for PQRI measures:

- The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
 - on the same claim as the denominator billing code(s)
 - for the same beneficiary
 - for the same date of service (DOS)
 - by the same EP (individual NPI) who performed the covered service as the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the denominator.
- All diagnoses reported on the base claim will be included in PQRI analysis, as some PQRI measures require reporting more than one diagnosis on a claim. For line items containing a QDC, only a single reference number in the diagnosis pointer field will pass into the National Claims History File. To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in PQRI analysis.
- Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically.
- If your billing software limits the number of line items available on a claim, you may add a nominal amount such as a penny, to one of the line items on that second claim for a total charge of one penny. PQRI analysis will subsequently join both claims based on the same beneficiary for the same date-of-service, for the same TIN/NPI and analyze as one claim. Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses or QDCs are not dropped.
- QDCs must be submitted with a line-item charge of zero dollars (\$0.00) at the time the associated covered service is performed.
 - The submitted charge field cannot be blank.
 - The line item charge should be \$0.00.
 - If a system does not allow a \$0.00 line-item charge, a nominal amount can be substituted – the beneficiary is not liable for this nominal amount.
 - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be \$0.00.)
 - Whether a \$0.00 charge or a nominal amount is submitted to the carrier/contractor, the PQRI code line is denied and tracked.
 - QDC line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. EPs will receive a Remittance Advice (RA) associated with the claim which will contain the PQRI quality-data code line-item and will include a standard remark code (N365) and a message that confirms that the QDCs passed into the National Claims History (NCH) file. N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does **NOT** indicate whether the QDC is accurate for that claim or for the measure the EP is attempting to report.

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- Keep track of all PQRI cases reported so that you can verify QDCs reported against the remittance advice notice sent by the carrier/MAC. Each QDC line-item will be listed with the N365 denial remark code.
- Multiple EPs' QDCs can be reported on the same claim using their individual NPI. Therefore, when a group is billing, they should follow their normal billing practice of placing the NPI of the individual EP who rendered the service on each line item on the claim including the QDC line(s).
- Some measures require the submission of more than one QDC in order to properly report the measure. Report each QDC as a separate line item, referencing one diagnosis and including the rendering provider NPI.
- Use of CPT II modifiers (1P, 2P, 3P, 8P) is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes.
- Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent).
- EPs may submit multiple codes for more than one measure on a single claim.
- Multiple CPT Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim.
- If a denied claim is subsequently corrected through the appeals process to the Carrier/AB MAC, with accurate codes that also correspond to the measure's denominator, then QDCs that correspond to the numerator should also be included on the resubmitted claim as instructed in the measure specifications.
- Claims may **NOT** be resubmitted for the sole purpose of adding or correcting QDCs.
- EPs should use the 8P reporting modifier judiciously for applicable measures they have selected to report. The 8P modifier may not be used indiscriminately in an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

Submission through Carriers/Medicare Administrative Contractors (MACs)

QDCs shall be submitted to carriers/MACs either through:

Electronic submission, which is accomplished using the **ASC X 12N Health Care Claim Transaction (Version 4010A1)**.

CPT Category II and/or temporary G-codes should be submitted in the **SV101-2 "Product/Service ID" Data Element** on the **SV1 "Professional Service" Segment** of the **2400 "Service Line" Loop**.

- It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.

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- Diagnosis codes are submitted at the claim level, **Loop 2300, in data element HI01**, and if there are multiple diagnosis codes, in **HI02 through HI08** as needed with a single reference number in the diagnosis pointer.
- In general for group billing, report the NPI for the rendering provider in **Loop 2310B** (Rendering Provider Name, claim level) or **2420A** (Rendering Provider Name, line level), using data elements **NM109 (NM108=XX)**.

OR

Paper-based submission, which is accomplished by using the **CMS-1500 claim form (version 08-05)**.

Relevant ICD-9-CM diagnosis codes are entered in **Field 21**. **Service codes** (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in **Field 24D** with a single reference number in the diagnosis pointer **Field 24E** that corresponds with the diagnosis number in **Field 21**.

- For group billing, the **National Provider Identifier (NPI)** of the rendering provider is entered in **Field 24J**.
- The **Tax Identification Number (TIN)** of the employer is entered in **Field 25**.

Group NPI Submission

When a group bills, the group's NPI is submitted at the claim level, therefore, the individual rendering physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

Solo NPI Submission

The individual NPI of the solo practitioner must be included on the claim line as is the normal billing process for submitting Medicare claims. For PQRI, the QDC must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in PQRI analysis.

CMS-1500 Claim Example

An example of a claim in CMS-1500 format that illustrates how to report measures groups is provided. See **Appendix B**.

Appendix A: 2010 PQRI Participation Decision Tree

I WANT TO PARTICIPATE IN 2010 PQRI FOR INCENTIVE PAYMENT

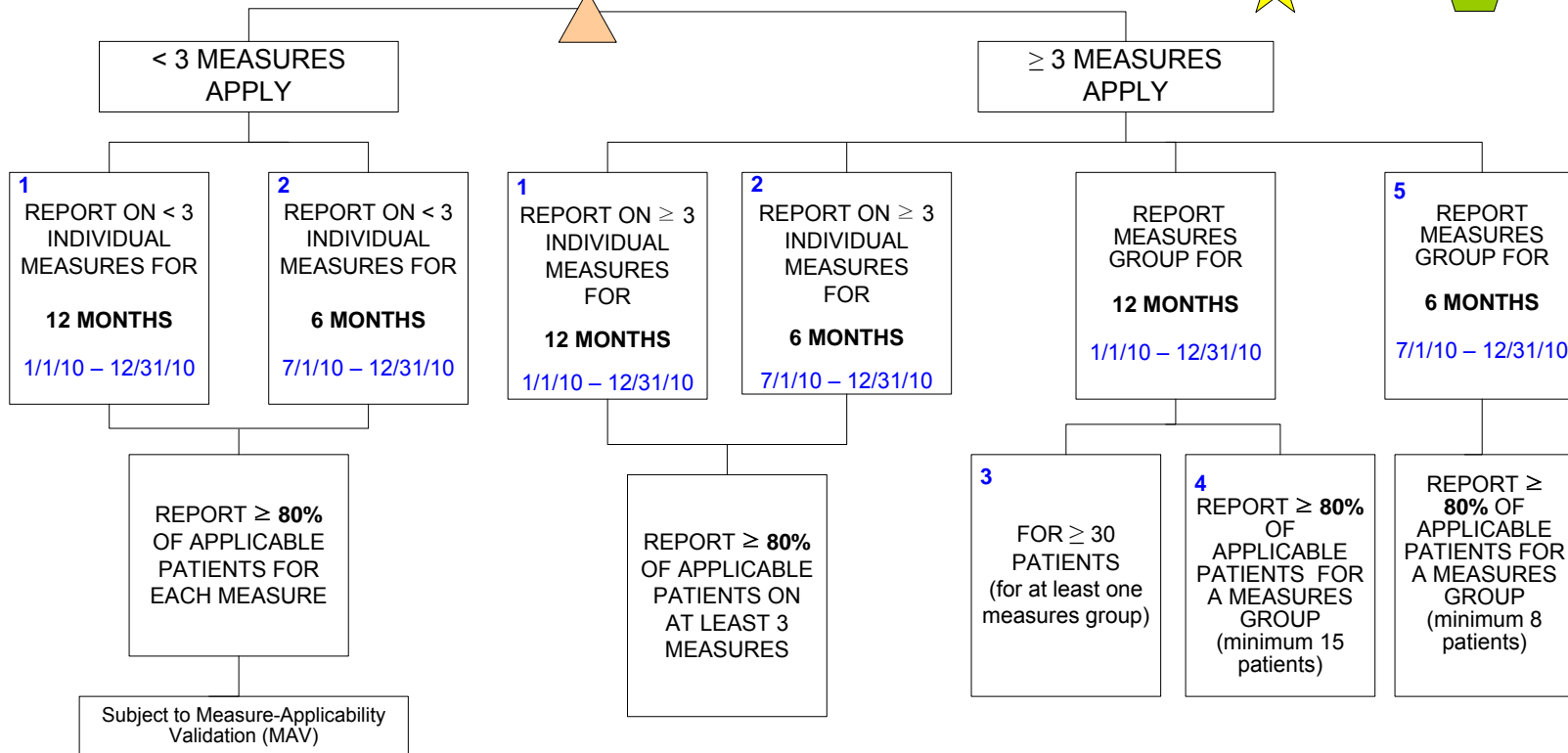
Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2010 PQRI)

CHOOSE CLAIMS-BASED REPORTING OPTIONS

REGISTRY-
BASED
REPORTING

EHR-BASED
REPORTING



I WANT TO PARTICIPATE IN 2010 PQRI FOR INCENTIVE PAYMENT

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2010 PQRI)

CLAIMS-BASED
REPORTING

**CHOOSE
REGISTRY-BASED REPORTING
OPTIONS**

EHR-BASED
REPORTING

≥ 3 MEASURES APPLY

**INDIVIDUAL
MEASURES**

MEASURES GROUP

6
SUBMIT ≥ 3
INDIVIDUAL MEASURES
FOR
12 MONTHS

1/1/10 – 12/31/10

7
SUBMIT ≥ 3
INDIVIDUAL MEASURES
FOR
6 MONTHS

7/1/10 – 12/31/10

SUBMIT DATA ON ≥ **80%**
OF APPLICABLE
PATIENTS ON AT LEAST
3 MEASURES

SUBMIT ≥ 1
MEASURES GROUP
FOR
12 MONTHS

1/1/10-12/31/10

SUBMIT ≥ 1
MEASURES GROUP
FOR
6 MONTHS

7/1/10-12/31/10

8
SUBMIT DATA ON 100%
OF **30** APPLICABLE
PATIENTS WITHIN 12
MONTHS (may include
some non-Medicare
patients)

9
SUBMIT DATA ON ≥
80% OF APPLICABLE
PATIENTS FOR A
MEASURES GROUP
(minimum 15 patients)

10
SUBMIT DATA ON ≥
80% OF APPLICABLE
PATIENTS FOR A
MEASURES GROUP
(minimum 8 patients)

I WANT TO PARTICIPATE IN 2010 PQRI FOR INCENTIVE PAYMENT

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2010 PQRI)

CLAIMS-BASED
REPORTING



REGISTRY-BASED
REPORTING



**CHOOSE
EHR-BASED REPORTING
OPTION**



≥ 3 MEASURES APPLY

11

SUBMIT ≥ 3 INDIVIDUAL
MEASURES FOR
12 MONTHS

1/1/10 - 12/31/10

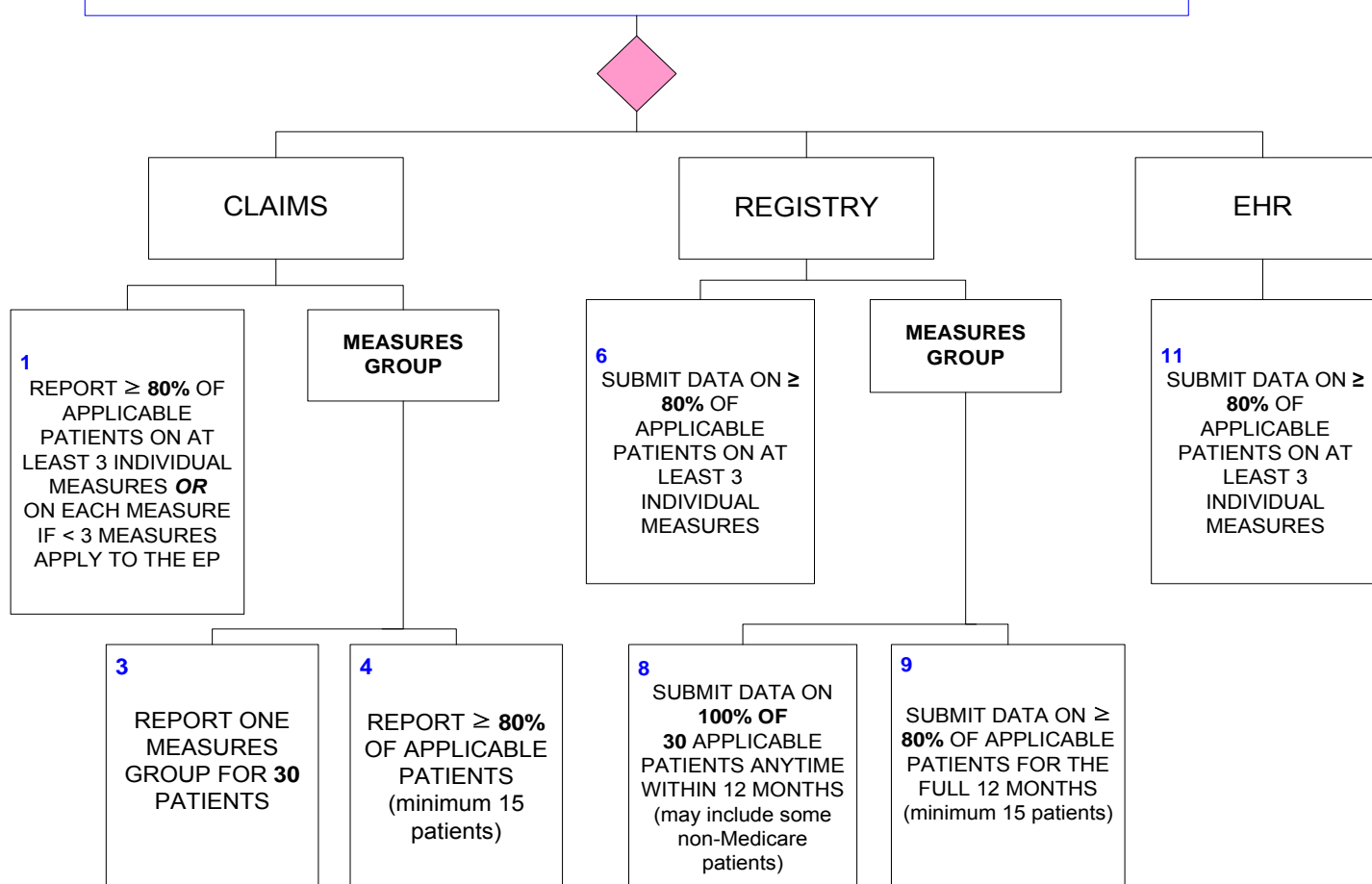
EHR SUBMITS DATA ON ≥
80% OF APPLICABLE
PATIENTS ON AT LEAST 3
INDIVIDUAL MEASURES

I WANT TO PARTICIPATE IN 2010 PQRI FOR INCENTIVE PAYMENT

(Select Reporting Period)

**12-MONTH
REPORTING PERIOD**
1/1/10 – 12/31/10

**6-MONTH
REPORTING PERIOD**
7/1/10 – 12/31/10



I WANT TO PARTICIPATE IN 2010 PQRI FOR INCENTIVE PAYMENT

(Select Reporting Period)

**12-MONTH
REPORTING PERIOD**
1/1/10 – 12/31/10



**6-MONTH
REPORTING PERIOD**
7/1/10 – 12/31/10



CLAIMS

REGISTRY

2
REPORT \geq **80%** OF
APPLICABLE
PATIENTS ON AT
LEAST 3 INDIVIDUAL
MEASURES **OR**
ON EACH MEASURE
IF < 3 MEASURES
APPLY TO THE EP

**MEASURES
GROUP**

5
REPORT \geq
80% OF
APPLICABLE
PATIENTS
(minimum 8)

7
SUBMIT DATA ON
 \geq **80%** OF
APPLICABLE
PATIENTS ON AT
LEAST 3
INDIVIDUAL
MEASURES

**MEASURES
GROUP**

10
SUBMIT DATA
ON \geq **80%** OF
APPLICABLE
PATIENTS

Appendix A: 2010 Participation Decision Tree

2010 PQRI Reporting Options

Number assigned coordinates with appropriate box on the Appendix C: 2010 PQRI Participation Decision Tree.

1. Claims-based reporting of individual measures (12 months)
2. Claims-based reporting of individual measures (6 months)
3. Claims-based reporting of one measures group for 30 Medicare Part B FFS patients (12 months)
4. Claims-based reporting of one measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients) (12 months)
5. Claims-based reporting of one measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 8 patients) (6 months)
6. Registry-based reporting of at least 3 individual PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (12 months)
7. Registry-based reporting of at least 3 individual PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (6 months)
8. Registry-based reporting of one measures group for 30 patients (patients may include, but may not be exclusively non-Medicare patients) (12 months)
9. Registry-based reporting of one measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients) (12 months)
10. Registry-based reporting of one measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 8 patients) (6 months)
11. EHR-based reporting of at least 3 individual PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (12 months)

Appendix B: CMS-1500 Claim [Detailed Measures Group] – Sample 1 (continues on next pg)

The following is a claim sample for reporting the Rheumatoid Arthritis (RA) Measures Group on a CMS-1500 claim and it continues on the next page. Two samples are included: one is for reporting of individual measures for the RA measures group; the second sample shows reporting performance of all measures in the group using a composite G-code. See http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage for more information.

21. Review and determine if ANY diagnosis (Dx) listed in Item 21 meets the patient sample criteria for the RA measures group.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier(s) as needed

Quality-Data Codes (QDCs) must be submitted with a line-item charge of \$0.00. Charge field **cannot be blank.**

For group billing, the rendering NPI number of the individual Eligible Professional (EP) who performed the service will be used from each line-item in the PQRI calculations.

Identifies claim line-item

Report ALL measures' QDCs within the RA measures group

The NPI of the billing provider is entered here. If a solo practitioner, then enter the individual NPI; if a Group is billing, enter the NPI of the group here. This is a required field.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Refer to Items 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE										23. PRIOR AUTHORIZATION NUMBER																																																																					
24. A. DATE(S) OF SERVICE										24. B. PLACE OF SERVICE										24. C. PROCEDURE, SERVICE, OR SUPPLY										24. E. DIAGNOSIS POINTER										24. F. \$ CHARGES										24. G. DAYS OR UNITS										24. H. EFFECTIVITY										24. I. D. QUALITY										24. J. RENDERING PROVIDER ID. #									
From To										EMG										CPT/HCPCS										MODIFIER																																																											
01 12 10 01 12 10 11										99202										Patient encounter during reporting period										45 00																														NPI 0123456789																													
01 12 10 01 12 10 11										G8490										RA Measures Group Intent G-code										0 00																														NPI 0123456789																													
01 12 10 01 12 10 11										4187F										RA-PQRI #108										0 00																														NPI 0123456789																													
01 12 10 01 12 10 11										3455F										RA-PQRI #176 code 1										0 00																														NPI 0123456789																													
01 12 10 01 12 10 11										4195F										RA-PQRI #176 code 2										0 00																														NPI 0123456789																													
01 12 10 01 12 10 11										3471F										RA-PQRI #177										0 00																														NPI 0123456789																													

25. FEDERAL TAX I.D. NUMBER SSN EIN
XX-XXXXXXX [X] [X]

26. PATIENT'S ACCOUNT NO. XXXXX

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [] NO

28. TOTAL CHARGE \$ 45 00

29. AMOUNT PAID \$

30. BALANCE DUE \$ 45 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

SIGNED DATE a. b. a. XXXXXXXXXXXX

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

The patient was seen for an office visit (99202). The provider reports all measures (#108, #176, #177, #178, #179, and #180) in the RA Measures Group:

- Intent G-code (G8490) was submitted to initiate the EP's submission of the RA Measures Group.
- Measure #108 (RA-DMARD Therapy) with QDC 4187F + RA line-item diagnosis (24E points to Dx 714.0 in Item 21);
- Measure #176 (RA-Tuberculosis Screening) with QDCs 3455F + 4195F + RA line-item diagnosis (24E points to Dx 714.0 in Item 21);
- Measure #177 (RA-Periodic Assessment of Disease Activity) with QDC 3471F + RA line-item diagnosis (24E points to Dx 714.0 in Item 21);

RA Measures Group Sample 1 continues on the next page.

Appendix B: CMS-1500 Claim [Detailed Measures Group] – Sample 1 (cont.)

If billing software limits the line items on a claim, you may add a nominal amount such as a penny to one of the QDC line items on that second claim for a total charge of \$0.01

21. Review and determine if ANY diagnosis (Dx) listed in Item 21 meets the patient sample criteria for the RA measures group.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier(s) as needed

QDC(s) must be submitted with a line-item charge of \$0.00 or \$0.01. Charge field cannot be blank.

For group billing, the rendering NPI number of the individual EP who performed the service will be used from each line-item in the PQRI calculations.

Identifies claim line-item

Report ALL measures' QDCs within the RA measures group

Solo practitioner - Enter individual NPI here

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE										ORIGINAL REF. NO.									
1. 714.0										Rheumatoid Arthritis (RA)										23. PRIOR AUTHORIZATION NUMBER									
2.										3.										24. A. DATE(S) OF SERVICE									
From MM DD YY										To MM DD YY										B. PLACE OF SERVICE									
C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER									
F. CPT/HCPCS										G. MODIFIER										F. CHARGES									
1. 01 12 10 01 12 10 11										1170F RA-PQRI #178										1 0 00									
2. 01 12 10 01 12 10 11										3476F RA-PQRI #179										1 0 01									
3. 01 12 10 01 12 10 11										4192F RA-PQRI #180										1 0 00									
4.																				NPI 0123456789									
5.																				NPI									
6.																				NPI									
25. FEDERAL TAX I.D. NUMBER										SSN EIN										26. PATIENT'S ACCOUNT NO.									
XX-XXXXXXX										XX XX										XXXXXX									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #									
SIGNED										DATE										a. XXXXXXXXXX									

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

- Measure #178 (RA-Functional Status Assessment) with QDC 1170F + RA line-item diagnosis (24E points to Dx 714.0 in Item 21);
- Measure #179 (RA-Assessment & Classification) with QDC 3476F + RA line-item diagnosis (24E points to Dx 714.0 in Item 21); and
- Measure #180 (RA-Glucocorticoid Management) with QDC 4192F + RA line-item diagnosis (24E points to Dx 714.0 in Item 21).
- **Note:** All diagnoses listed in Item 21 will be used for PQRI analysis. (Measures that require the reporting of two or more diagnoses on a claim will be analyzed as submitted in Item 21.)
- **NPI placement:** Item 24J must contain the NPI of the individual provider that rendered the service when a group is billing.

Appendix B: CMS-1500 Claim [Sample Measures Group] – Sample 2

A detailed sample of an individual NPI reporting the RA Measures Group on a related CMS-1500 claim is shown below. This sample shows reporting performance of all measures in the group using a composite G-code. See http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage for more information.

21. Review and determine if ANY diagnosis (Dx) listed in Item 21 meets the patient sample criteria for the RA measures group.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier(s) as needed

ODC(s) must be submitted with a line-item charge of \$0.00. Charge field cannot be blank.

For group billing, the rendering NPI number of the individual EP who performed the service will be used from each line-item in the PQRI calculations.

Identifies claim line-item

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (List 1, 2, 3, or 4 to Item 24E by Line)

714 0 Rheumatoid Arthritis (RA)

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. ICD-9-CM CODE I. D. QUAL J. RENDERING PROVIDER ID. #

1 01 12 10 01 12 10 11 99202 Patient encounter during reporting period 45 00 NPI 0123456789

2 01 12 10 01 12 10 11 G8490 RA Measures Group Intent G-code 0 00 NPI 0123456789

3 01 12 10 01 12 10 11 G8499 RA Measures Group ODC indicating all quality actions were performed for this patient 0 00 NPI 0123456789

4

5

6

25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE

XX-XXXXXXX [X] [] XXXXX [X] YES [] NO \$ 45 00 \$ \$ 45 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #

SIGNED DATE a. b. a. XXXXXXXXXXXX

Solo practitioner - Enter individual NPI here

NUCC Instruction Manual available at: www.nucc.org

The patient was seen for an office visit (99202). The provider reports all measures (#108, #176, #177, #178, #179, and #180) in the RA Measures Group:

- Intent **G-code (G8490)** was submitted to initiate the EP's submission of the RA Measures Group.
- Measures Group **QDCComposite G-code G8499** (indicating all quality actions related to the RA Measures Group were performed for this patient) + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**). The composite G-code G8499 may not be used if performance modifiers (1P, 2P, 3P, or G-code equivalent) or the 8P reporting modifier apply.
- **Note:** All diagnoses listed in **Item 21** will be used for PQRI analysis. (Measures that require the reporting of two or more diagnoses on claim will be analyzed as submitted in Item 21.)
- **NPI placement:** **Item 24J** must contain the NPI of the individual provider that rendered the service when a group is billing.